IDAHO DEPARTMENT OF
# HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

November 24, 2010

Ferren Weeks, Administrator
Yellowstone Group Home #1 Springfield
560 West Sunnyside
Idaho Falls, ID 83401

RE: Yellowstone Group Home #1 Springfield, Provider #13G063

Dear Mr. Weeks:

This is to advise you of the findings of the Medicaid/Licensure survey of Yellowstone Group Home #1 Springfield, which was conducted on November 18, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner**:

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of

being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **December 6, 2010,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by December 6, 2010. If a request for informal dispute resolution is received after December 6, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

BARBARA DERN
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

BD/srm
Enclosures

**Yellowstone**
**Group Homes**

560 W Sunnyside
Idaho Falls, ID 83402

December 3, 2010

Barbara Dern
Idaho Department of Health and Welfare
Bureau of Facility Standards
3232 Elder St
Boise, ID 83720-0036

Dear Barbara Dern:

This is the Plan of Correction for the survey concluded at Yellowstone group Home #1 Springfield, on November 18, 2010. I would like to take the opportunity to thank you and Jim Troutfetter for the helpful information you always share. The survey process is always a learning experience, and you certainly made it helpful as well as pleasant. Thanks so much.

Sincerely,

Steve Young
Administrator

PRINTED: 11/23/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G063 | A. BUILDING _____ B. WING _____ | 11/18/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| YELLOWSTONE GROUP HOME #1 SPRINGFIELD | 3335 SPRINGFIELD IDAHO FALLS, ID 83404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| W 000 | INITIAL COMMENTS<br><br>The following deficiencies were cited during the annual recertification survey.<br><br>The survey was conducted by:<br>Barbara Dern, QMRP, Team Leader<br>Jim Troutfetter, QMRP<br><br>Common abbreviations/symbols used in this report are:<br>ADHD - Attention Defecit Hyperactivity Disorder<br>HRC - Human Rights Committee<br>IPP - Individual Program Plan<br>LPN - Licensed Practical Nurse | W 000 | | |
| W 262 | 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE<br><br>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only with the approval of the facility's HRC for 1 of 3 individuals (Individual #1) whose consents were reviewed. This resulted in the potential for an individual to receive unnecessary medications. The findings include:<br><br>1. Individual #1's IPP, dated 5/20/10, documented a 15 year old male diagnosed with moderate mental retardation, ADHD, and Asperger's Syndrome. | W 262 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Springfield Administrator 12-3-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| W 262 | Continued From page 1<br>His record contained a Physician's Order, dated 11/3/10, documenting he received perphenazine (an antipsychotic drug) 2 mg at bedtime. However, his record did not contain HRC consent for the drug.<br><br>When asked, the LPN stated during an interview on 11/17/10 from 4:05 - 4:10 p.m., HRC consent was not obtained for perphenazine.<br><br>The facility failed to ensure HRC approval was obtained for the use of perphenazine for Individual #1. | W 262 | See attached Plan of Correction | |
| W 263 | 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE<br><br>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only with written informed consent of a guardian for 1 of 3 individuals (Individual #1) whose consents were reviewed. This resulted in a lack of protection of an individual's rights through prior approval of behavior modifying drugs. The findings include:<br><br>1. Individual #1's IPP, dated 5/20/10, documented a 15 year old male diagnosed with moderate mental retardation, ADHD, and Asperger's Syndrome.<br><br>His record contained a Physician's Order, dated 11/3/10, documenting he received perphenazine | W 263 | ~~Refer to~~ See attached Plan of Correction | |

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| W 263 | Continued From page 2<br>(an antipsychotic drug) 2 mg at bedtime. However, his record did not contain guardian consent for the drug.<br><br>When asked, the LPN stated during an interview on 11/17/10 from 4:05 - 4:10 p.m., guardian consent was not obtained for perphenazine.<br><br>The facility failed to ensure guardian approval was obtained for the use of perphenazine for Individual #1. | W 263 | | |
| W 312 | 483.450(e)(2) DRUG USAGE<br><br>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of an individual's IPP that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 1 of 3 individuals (Individual #1) whose medication reduction plans were reviewed. This resulted in an individual receiving behavior modifying drugs without plans that identified the drugs usage and how they may change in relation to progress or regression. The findings include:<br><br>1. Individual #1's IPP, dated 5/20/10, documented a 15 year old male diagnosed with moderate mental retardation, ADHD, and Asperger's | W 312 | Refer to W 262 & W 263. | |

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| W 312 | Continued From page 3<br>Syndrome.<br><br>His record contained a Physician's Order, dated 11/3/10, documenting he received perphenazine (an antipsychotic drug) 2 mg at bedtime. However, his record did not contain a plan related to the use of the drug.<br><br>When asked, the LPN stated during an interview on 11/17/10 from 4:05 - 4:10 p.m., there was no plan related to perphenazine.<br><br>The facility failed to ensure a plan was developed for Individual #1's perphenazine. | W 312 | | |
| W 382 | 483.460(l)(2) DRUG STORAGE AND RECORDKEEPING<br><br>The facility must keep all drugs and biologicals locked except when being prepared for administration.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, it was determined the facility failed to ensure all drugs and biologicals were maintained under locked conditions. This failure directly impacted 6 of 6 individuals (Individuals #1 - #6), residing in the facility. This resulted in the potential for harm in the event individuals accessed and ingested a drug. The findings include:<br><br>During an environmental assessment conducted on 11/17/10, from 9:45 - 10:15 a.m., a cabinet in the kitchen containing various over the counter medications used for routine standing orders was noted to be unlocked. The maintenance supervisor, who was present stated the lock on the cabinet was damaged and the cabinet should | W 382 | See attached plan of Correction | |

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| W 382 | Continued From page 4<br>have been locked. The maintenance supervisor temporarily repaired the lock and stated a permanent repair would be made.<br><br>The facility failed to ensure all medications were kept secured when not in use. | W 382 | | |

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| MM194 | 16.03.11.075.10(a) Approval of Human Rights Committee<br><br>Has been reviewed and approved by the facility's human rights committee; and<br>This Rule is not met as evidenced by:<br>Refer to W262. | MM194 | Refer to W 262 | |
| MM196 | 16.03.11.075.10(c) Consent of Parent or Guardian<br><br>Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and<br>This Rule is not met as evidenced by:<br>Refer to W263. | MM196 | Refer to W 263 | |
| MM197 | 16.03.11.075.10(d) Written Plans<br><br>Is described in written plans that are kept on file in the facility; and<br><br>This Rule is not met as evidenced by:<br>Refer to W312. | MM197 | Refer to W 312 | |
| MM380 | 16.03.11.120.03(a) Building and Equipment<br><br>The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents.<br>This Rule is not met as evidenced by:<br>Based on observation, it was determined the | MM380 | See attached Plan of Correction | |

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Springfield Administrator (X6) DATE 12-3-10

STATE FORM 6899 XW3C11 If continuation sheet 1 of 2

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| MM380 | Continued From page 1<br>facility failed to ensure the facility was kept clean, sanitary, and in good repair for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include:<br><br>1. An environmental review was conducted on 10/17/10 from 9:45 - 10:15 a.m. During that time, the following was noted:<br><br>- The toilet in the hallway bathroom had a crack in the base approximately 6 inches long.<br><br>- The the left cushion on the couch (when facing the couch), under the window, was worn and unable to provide support to those seated on it.<br><br>The facility failed to ensure environmental repairs were maintained. | MM380 | See attached Plan of Correction | |
| MM753 | 16.03.11.270.02(f)(i) Locked Area<br><br>All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by: Refer to W382. | MM753 | Refer to W382 | |